Kamalam a/p Raman & Ors v Eastern Plantation Agency (Johore) Sdn Bhd Ulu Tiram Estate, Ulu Tiram, Johore & Anor

HIGH COURT (MUAR) — CIVIL SUIT NO 25–75 OF 1986
RICHARD TALALLA J
6 SEPTEMBER 1995

Tort *— Damages — Professional negligence — Death due to medical negligence — Deceased having high risk lifestyle — Whether only nominal damages should be awarded*

Tort *— Professional negligence — Medical practitioner — Standard of care and skill expected — Not admitting patient to hospital resulting in death of patient — Whether doctor negligent if he acts in accordance with the practice accepted as proper by a body of medical opinion — Whether standard of care should be determined by court or profession*

Civil Procedure *— Costs — Fees for more than one counsel — When allowed — Rules of the High Court 1980 O 59 r 19(1)*

Civil Procedure *— Pleadings — Necessity for express pleadings — Surprise defence — Whether should be allowed — Rules of the High Court 1980 O 18 r 8(1)*

Labour Law *— Employment — Employer's duty — Safe and efficient transport to and from hospital — Workers' Minimum Standards of Housing and Amenities Act 1990 s 18*

The late Mr Dinasan a/l Padmanbathan ('Mr D') was employed by the first defendant at the time of his death and was staying on the estate owned by the first defendant. Mr D had been suffering from hypertension since 1981. On 3 July 1984 Mr D complained of giddiness and fainted at work. He was taken to the estate clinic where he was attended to by a Dr Wong. He was examined, prescribed medication and discharged. On 6 July 1984 and 10 July 1984 he was attended to at the clinic by a Dr Yoong, the second defendant. On 11 July 1984, as a result of giddiness and fits, Mr D was taken to the Kluang Hospital for emergency treatment and was subsequently transferred to the Johor Bahru Hospital. He passed away in hospital on 12 July 1984, leaving a wife (the first plaintiff) and three children (the second, third and fourth plaintiffs). The plaintiffs brought a claim against the first defendant for negligence in failing to provide adequate medical facilities and against the second defendant for negligence in failing to diagnose the nature of Mr D's ailment, which was a stroke, and failing to admit him to a hospital.

Held, allowing the plaintiffs' claim against the second defendant with costs and no order as to costs as between the plaintiffs and the first defendant:

(1) A man or a woman who practises a profession is bound to exercise the care and skill of an ordinary competent practitioner in that profession. Every person who enters into a learned profession undertakes to bring to the exercise of it a reasonable degree of care and skill (see pp 686E–F, 690F; *Swawy v Matthews*

& Anor [1968] 1 MLJ 138 and *Kow Nan Seng v Nagamah & Ors* [1982] 1 MLJ 128 followed).

(2) The standard of care to be observed by a person with some special skill or competence is that of the ordinary skilled person exercising and professing to have that special skill. That standard of care is not determined solely or even primarily by reference to the practice followed or supported by a responsible body of opinion in the relevant profession or trade. The ultimate question is whether it conforms to the standard of reasonable care demanded by the law. That is a question for the court and the duty of deciding it cannot be delegated to any profession or group in the community (see pp 688F–G, 689A; *Rogers v Whitaker* (1992) 175 CLR 479 followed; *Bolam v Friern Hospital Management Committee* [1957] 2 All ER 118 and *Elizabeth Choo v Government of Malaysia & Anor* [1970] 2 MLJ 171 distinguished).

(3) The second defendant failed in his duty as a doctor to his patient in deciding not to admit him into hospital and deciding that medical leave was not necessary and declining to give it. The fact that Mr D was not hospitalized caused or contributed to the cause of his death (see pp 694C–D, 695I).

(4) By reference to the pleadings and the evidence, the second defendant admitted that the practice was his, so a presumption arose that Dr Wong was his servant or agent (see p 698B; *Barnard v Sully* (1931) 47 TLR 557 followed). Having admitted that the practice was his, the defence of the second defendant that Dr Wong was not his servant or agent was vague, calculated to take the plaintiffs by surprise and in breach of the requirement of O 18 r 8(1) of the Rules of the High Court 1980 ('the RHC'). Raising the issue at the eleventh hour was tantamount to trial by ambush and this was not permissible. The second defendant was vicariously or as a partner liable for the acts of Dr Wong (see pp 698C–D, 699D; *Asia Hotel Sdn Bhd v Malayan Insurance (M) Sdn Bhd* [1992] 2 MLJ 615 followed).

(5) It was quite impossible to assess how much longer Mr D would have lived had he been properly and at the right time admitted to hospital by Dr Wong and/or the second defendant. Mr D, because of his chosen lifestyle and habits, should himself be taken as having elected for a reduced expectation of life. As such, only nominal damages should be awarded for the second defendant's breach of duty (see p 699E–F).

(6) This was a proper case for more than one counsel to have appeared for the plaintiffs and pursuant to O 59 r 19(1) of the RHC, fees for two counsel for the plaintiffs would be allowed (see p 699G–H).

(7) The first defendant was negligent in failing to provide an efficient ambulance service at the material time. It also offended s 18 of the Workers' Minimum Standards of Housing and Amenities

Act 1990. However, the evidence disclosed no nexus between the first defendant's default and the cause of Mr D's demise (see pp 699H–700D). A

[Bahasa Malaysia summary

Mendiang Encik Dinasan a/l Padmanbathan ('Encik D') berada di bawah penggajian defendan pertama pada waktu kematiannya dan telah tinggal di estet kepunyaan defendan pertama. Encik D telah mengalami hipertensi sejak tahun 1981. Pada 3 Julai 1984 Encik D telah mengadu pening kepala dan telah pengsan di tempat kerjanya. Dia telah dibawa ke klinik estet di mana dia telah dirawat oleh seorang bernama Dr Wong. Beliau telah diperiksa, diberikan ubat dan dibenarkan balik. Pada 6 Julai 1984 dan 10 Julai 1984, beliau telah dirawat di klinik itu oleh seorang bernama Dr Yoong, iaitu defendan kedua. Pada 11 Julai 1984, akibat kepeningan kepala dan sawan, Encik D telah dibawa ke Hospital Kluang untuk rawatan kecemasan dan telah kemudiannya dipindahkan ke Hospital Johor Bahru. Beliau telah meninggal dunia di hospital pada 12 Julai 1984, meninggalkan seorang isteri (plaintif pertama) dan tiga orang anak-anak (plaintif-plaintif kedua, ketiga dan keempat). Plaintif-plaintif telah membawa tuntutan terhadap defendan pertama untuk kecuaian kerana gagal untuk membekalkan kemudahan perubatan yang memadai dan terhadap defendan kedua untuk kecuaian kerana gagal untuk mendiagnosis jenis penyakit yang dialami oleh Encik D, iaitu strok, dan gagal untuk memasukkannya ke dalam hospital. B C D E

Diputuskan, membenarkan tuntutan plaintif-plaintif terhadap defendan kedua dengan kos and tiada perintah untuk kos di antara plaintif dan defendan pertama: F

(1) Seseorang lelaki atau perempuan yang mengamal sesuatu profesion adalah terikat untuk menggunakan kecermatan dan kemahiran seorang pengamal biasa yang kompeten dalam profesion tersebut. Semua orang yang memasuki sesuatu profesion berilmu memberi akujanji untuk menggunakan tahap berjaga-jaga dan kemahiran yang munasabah (lihat ms 686E–F, 690F; *Swamy v Matthews & Anor* [1968] 1 MLJ 138 dan *Kow Nan Seng v Nagamah & Ors* [1982] 1 MLJ 128 diikut). G

(2) Taraf berjaga-jaga yang patut diperhatikan oleh seseorang yang mempunyai kemahiran atau kompetens khas adalah taraf berjaga-jaga seorang yang berkemahiran biasa yang menggunakan dan dikatakan mempunyai kemahiran khas itu. Taraf berjaga-jaga tersebut tidak ditentukan hanya atau khususnya dengan merujuk kepada amalan yang diikut atau disokong oleh satu badan pendapat yang bertanggungjawab di dalam profesion atau perdagangan yang berkenaan. Persoalan utama adalah sama ada ia mematuhi taraf berjaga-jaga munasabah yang dikehendaki di sisi undang-undang. Itu adalah suatu persoalan untuk mahkamah dan kewajipan untuk memutuskannya tidak boleh dialihkan kepada mana-mana profesion atau kumpulan dalam masyarakat H I

(lihat ms 688F–G, 689A; *Rogers v Whitaker* (1992) 175 CLR 479 diikut; *Bolam v Friern Hospital Management Committee* [1957] 2 All ER 118 dan *Elizabeth Choo v Government of Malaysia & Anor* [1970] 2 MLJ 171 dibeza).

(3) Defendan kedua telah gagal dalam kewajipannya selaku doktor kepada pesakitnya apabila beliau memutuskan bahawa pesakitnya tidak perlu dimasukkan ke hospital dan bahawa cuti sakit adalah tidak perlu dan enggan memberi cuti sakit sedemikian. Fakta bahawa Encik D telah tidak dimasukkan ke dalam hospital menyebabkan atau menyumbang kepada sebab kematiannya itu (lihat ms 694C–D, 695I).

(4) Dengan merujuk kepada pliding dan keterangan, defendan kedua telah mengakui bahawa amalan itu adalah kepunyaannya, maka timbul anggapan bahawa Dr Wong adalah pengkhidmat atau ejennya (lihat ms 698B; *Barnard v Sully* (1931) 47 TLR 557 diikut). Setelah mengakui bahawa amalan itu adalah kepunyaannya, pembelaan defendan kedua bahawa Dr Wong bukanlah pengkhidmat atau ejennya adalah taksa, dihitung untuk memeranjatkan plaintif-plaintif dan melanggar kehendak A 18 k 8(1) Kaedah-kaedah Mahkamah Tinggi 1980 ('KMT'). Menimbulkan isu ini di saat-saat terakhir adalah sama seperti perbicaraan secara menyerang hendap dan ini adalah tidak dibenarkan. Defendan kedua bertanggungan secara vikarius atau selaku seorang pekongsi untuk tindakan Dr Wong (lihat ms 698C–D, 699D; *Asia Hotel Sdn Bhd v Malayan Insurance (M) Sdn Bhd* [1992] 2 MLJ 615 diikut).

(5) Adalah hampir mustahil untuk menganggarkan berapa lama lagi Encik D mungkin terus hidup jika beliau secara berpatutan dan pada masa yang betul telah dimasukkan ke hospital oleh Dr Wong dan/atau defendan kedua. Encik D, akibat cara hidupnya yang dipilih dan tabiatnya, mesti dianggap sebagai telah membuat pilihan untuk jangkaan hidup yang kurang. Oleh itu, cuma ganti rugi nominal patut diaward untuk keingkaran tugas oleh defendan kedua (lihat ms 699E–F).

(6) Ini adalah kes sesuai untuk lebih daripada seorang peguambela hadir bagi pihak plaintif-plaintif dan menurut A 59 k 19(1) KMT, fee untuk dua orang peguambela untuk plaintif-plaintif akan dibenarkan (lihat ms 699G–H).

(7) Defendan pertama telah cuai kerana gagal menyediakan perkhidmatan ambulan yang efisien pada waktu yang berkenaan. Ia juga telah menyalahi s 18 Akta Taraf-Taraf Minima Perumahan dan Kemudahan Pekerja 1990. Walau bagaimanapun, keterangan tidak mendedahkan pengkaitan di antara kegagalan defendan pertama dan sebab kematian Encik D (lihat ms 699H–700D).]

Notes

For cases on necessity of express pleadings, see 2 *Mallal's Digest* (4th Ed, 1994 Reissue) paras 2613–2629.

For cases on employer's duty, see 8 *Mallal's Digest* (4th Ed, 1996 Reissue) paras 669–713.
For cases on professional negligence, see 12 *Mallal's Digest* (4th Ed) paras 357–375.

Cases referred to

Asia Hotel Sdn Bhd v Malayan Insurance (M) Sdn Bhd [1992] 2 MLJ 615
Barnard v Sully (1931) 47 TLR 557
Bolam v Friern Hospital Management Committee [1957] 2 All ER 118
Elizabeth Choo v Government of Malaysia & Anor [1970] 2 MLJ 171
Hunter v Hanley (1955) SLT 213
Kow Nan Seng v Nagamah & Ors [1982] 1 MLJ 128
Rogers v Whitaker (1992) 175 CLR 479
Swamy v Matthews & Anor [1968] 1 MLJ 138

Legislation referred to

Rules of the High Court 1980 O 18 r 8(1), O 59 r 19(1)
Workers' Minimum Standards of Housing and Amenities Act 1990 s 18

RK Nathan & E Ramasamy (*RK Nathan & Co, E Ramasamy & Co*) for the plaintiffs.
Wan Mansor bin Wan Mahmood (*Roslani & AJ Arifin*) for the first defendant.
S Radhakrishnan & G Chacko Vadaketh (*Shearn Delamore & Co*) for the second defendant.

Richard Talalla J: The late Mr Dinasan a/l Padmanbathan ('Mr D') passed away on 12 July 1984 aged 55 years and some months. He was at that time employed as a conductor by the first defendant ('the Estate') working and staying at a division of Ulu Tiram Estate called Ladang Tereh Utara, Kluang Johor, owned by the Estate, having retired from that employment and then been re-employed on a six-month extension till 20 August 1984. Ulu Tiram Estate comprised 14,500 acres and consisted of three divisions, namely Ladang Tereh Utara, Ladang Tereh Central and Ladang Tereh Selatan. About 350 workers were employed on Ladang Tereh Utara and the same number employed on Ladang Tereh Selatan. Ladang Tereh Central, which was in fact an oil mill, had about 100 workers. All three divisions provided medical facilities to the employees and their families. There were three clinics on Ulu Tiram Estate and two hospital assistants were employed by the Estate. However there was only one ambulance to provide services to all the three divisions. If there were more than one emergency a private car would be used. The distance from the Estate to Kluang District Hospital ('the Kluang Hospital') and the clinic ('the clinic') of the second defendant ('Dr Y') who was the Estate's visiting medical officer, is approximately 25 miles.

Mr D had been suffering from hypertension since 1981. He left a widow Mrs Dinasan ('Mrs D'), the first plaintiff, and three children ('the children'), the second, third and fourth plaintiffs who were then staying

with him. Hereafter unless otherwise stated all references to months are to the year 1984.

The plaintiffs claim by reference to the pleadings and the evidence that on 3 July at about 4.30pm the deceased while at work complained of giddiness and had fainted. He was then attended to by Mr Pospanathan who was the hospital assistant ('the HA') attached to the clinic ('the Estate clinic') at Ladang Tereh Utara. The HA, upon observing Mr D's condition, took him, in his, the HA's car, to the clinic for further treatment. On arrival at the clinic Mr D was attended to by one Dr Wong ('Dr W') who examined him, prescribed medication and then discharged him. On 6 July and 10 July Mr D was attended to by Dr Y at the clinic. On 11 July as a result of giddiness and fits Mr D was taken to the Kluang Hospital in a semi-conscious state where he was given emergency treatment and subsequently transferred to the Sultanah Aminah Hospital, Johore Bahru ('the JB Hospital') as the facilities in Kluang were inadequate for his immediate treatment at that late stage. On arrival at the JB Hospital at 2pm, Mr D was found to be bleeding profusely from the nose and mouth. He then became unconscious and passed away on 12 July at 12.05am.

The plaintiffs pleaded that the death of Mr D was caused by the negligence of the Estate and Dr Y and/or their servants or agents, the particulars of negligence of the Estate being that the Estate had failed to provide at the Estate clinic and generally adequate medical facilities for diagnosis and treatment including during emergencies, and to refer Mr D to either of the hospitals abovestated or to a medical specialist for proper diagnosis and treatment. The pleaded particulars of negligence of Dr Y were that he failed to investigate and diagnose the nature of Mr D's ailment in that he was having a stroke, that he had permitted the health of Mr D to deteriorate, that he failed to have him admitted to either of the said hospitals, that he did not refer him to a medical specialist and that he had failed to exercise any reasonable care, skill or diligence in diagnosis and in the administration of drugs.

The HA, one Dr Singaraveloo ('Dr S'), a specialist physician at the JB Hospital and one Dr Ridzwan bin Bakar ('Dr R'), a consultant physician and cardiologist with Pantai Medical Centre, Kuala Lumpur testified on behalf of the plaintiffs, as did Mrs D.

The HA had been employed as such by the Estate since January 1982. He testified that on 18 April he referred Mr D to Dr W on a complaint of chest pain, that he did not accompany Mr D on that occasion and did not know whether Dr W in fact treated Mr D; that on 12 May he reviewed Mr D's blood pressure, doing so again on 19 May and again on 13 June and yet again on 2 July; on all these occasions he found Mr D's blood pressure to be within a stable level. He further testified that a patient cannot go the hospital on his own accord unless he is referred by the company doctor and that according to his records, Mr D did not go to the hospital until 11 July. Of all the visits Mr D made to the clinic, he had followed Mr D to the clinic once, that being on the first occasion in July. He testified that on all four occasions Mr D was under medication for high blood pressure and that Mr D was on this treatment since 1981. The HA was then referred to the Estate's outpatient register book and he admitted

that the particulars of treatment of Mr D therein were entered by him. He also confirmed in evidence that Mr D's first visit to the clinic was on 18 April and that prior to that Mr D was undergoing treatment. He testified that the first occasion he had physically treated Mr D was on 26 October 1982 and that he was informed by Mr D that he was on follow-up treatment from the Kluang Hospital. On 3 July at about 10am he had seen Mr D riding his motorcycle, and he testified that he had attended to Mr D that same day when he fainted while working in the Estate office. There were symptoms of slurring of speech and twitching of his right arm and Mr D had complained of numbness of the right hand. The whole episode, which happened at 5pm, lasted about five minutes, and he immediately took Mr D and Mrs D in his car to the clinic. He testified that it took one hour to reach the clinic, which was normal and that on arrival at the clinic he explained Mr D's condition to Dr W, who then examined Mr D physically and said Mr D was normal and gave him some medication. He further testified that Dr W had told him, the HA, that one of the small arteries was going into spasm and that was why Mr D was getting these kind of attacks and it was normal and usual for an old high blood pressure case to get these kind of symptoms.

The HA went on to testify that on 5 and 6 July he visited Mr D at his home to see his condition and after a brief examination of his blood pressure he gave Mr D medical leave for the day. On 7 July Mr D again complained of numbness and pain in the hand and he immediately referred Mr D to the clinic for observation and treatment and that on 8 and 9 July he visited Mr D at his house and found his condition improving. The HA testified that in the early hours of 10 July he rushed to Mr D's house and found him complaining of numbness of the fingers and similar attacks on the hand, but after examination Mr D did not have any of those symptoms complained of. He was however referred to the clinic that morning, with a letter to Dr Y requesting him to refer Mr D to a hospital, so the HA testified, but Mr D returned home the same day from the clinic after being certified normal. The HA went on to say in evidence that that evening, between the hours of 7 and 8pm, Mr and Mrs D attended a Hari Raya party hosted by the Estate's assistant manager. On 11 July at about 1am he, on being informed that Mr D was very ill, rushed to his house to find him in an unconscious state, vomiting and frothing from the mouth. He then rushed Mr D to the Estate's central clinic which was about four miles away in an employee's car to obtain the service of the Estate's ambulance, but it was not there. The ambulance was finally located at Ladang Tereh Selatan and thereafter Mr D was sent to the Kluang Hospital accompanied by Mrs D and the hospital assistant of Ladang Tereh Selatan.

The HA further testified that it was not compulsory for Mr D to attend that Hari Raya party, that he did so of his own accord and that it was not advisable for him to attend the party, given his condition that morning and being then on five days' medical leave he was expected to rest. The HA testified that he had known Mr D since he, the HA, joined the Estate and that Mr D used to play games during his employment with the Estate when he was well and had not complained of any ailment arising out of the games he played. He further testified that if a person feels alright

and his pressure is maintained it is alright for him to play games. The HA testified that in the time he had known Mr D he had seen Mr D smoking and during social functions he had seen Mr D drinking beer but had not come across him drunk, and that drinking and smoking would affect his condition to a certain extent. The HA testified that it was not normal for him to recommend or advise Dr Y as to what he should do, however, he did recommend to Dr Y that Mr D be referred to the Kluang Hospital for further treatment and this was based on the fact that Mr D had frequently complained of chest pain and that on 3 July he had personally seen and attended to the symptoms of slurring of speech, twitching of the right hand, numbness and pain. It was under these circumstances that he made such recommendation to Dr Y. Mrs D gave evidence saying that she was married to Mr D for 26 years during which Mr D had drunk and smoked and as such his health had deteriorated; thereafter Mr D would only drink occasionally, and she testified that he had stopped consuming alcohol a week before his death. Mrs D also testified that her husband, Mr D smoked one packet of 20 cigarettes a day and had reduced this habit of smoking when he fell ill; she further testified that no one gave Mr D advice on smoking and drinking but she, Mrs D, had advised Mr D to stop smoking and drinking but he continued in spite of such advice.

Dr S testified that he was a specialist physician with the JB Hospital and that on being told of the blood pressure of Mr D measuring 180/120, he considered it to be high. Dr S went on to testify that under such circumstances and accompanied with chest discomfort, from the point of view of a general practitioner, he would have taken a detailed history of the patient and his blood pressure, and inquired as to whether he was on any treatment as well as the cause of the high blood pressure, whether it was genetically caused or whether there was some other underlying disease such as kidney disease, hormone excesses, abnormal arteries or tumours. He would then have asked for a detailed history of the chest discomfort to decide whether there was a cardiac problem or not as this would have been a symptom of angina. He testified that he would then have examined the patient to ascertain the abovestated conditions, that he would then have liked to rest Mr D for a while in the clinic and repeat the blood pressure taking and also do an electrocardiogram (ECG) and thereafter if the blood pressure was still high, he could have referred Mr D to the hospital for admission. Dr S was shown Dr W's case note of Mr D's visit on 3 July and after perusing the same, he testified that the review evidenced by that note was grossly inadequate by reference to what he, Dr S, would have done in the circumstances and that having made the diagnosis of cerebro vascular insufficiency (CVI), the doctor should have inquired into the cause of the high blood pressure and then referred Mr D who was then still middle-aged to a hospital specialist for further investigation and treatment.

Dr S was then referred to Dr Y's case note of the visit on 6 July and relying on the inscription thereon that the blood pressure was raised, that there were complaints of parasthesia of the right fingers and pain over the left eye he would have connected these symptoms as constituting an impending stroke and immediately would have referred Mr D to the hospital for closer observation, and any delay in so doing could have

caused a dangerous stroke. However Dr S admitted that at that point of time there was some attempt being made to treat the high blood pressure when the doctor prescribed brenerdine but Dr S was of the opinion that this symptom of parasthesia was an ominous sign and taking all these symptoms into account he was certain that Mr D required urgent referral to a hospital specialist and even a neurologist if possible. Dr S was then referred to Dr Y's case note of the visit on 10 July and from that recording he confirmed that there was reduced supply of blood to the brain and that the doctor should have anticipated the development of stroke and as such he should have referred Mr D to a hospital specialist for investigation and to provide treatment accordingly. What should have been done in these circumstances was to refer Mr D to the hospital with a specialist so that he could be examined and given early treatment. Dr S was of the view that an early referral to the hospital with specialist treatment, would have enabled such hospital to carry out investigations such as doing an angiogram or arteriogram and to take the necessary precautionary measures to prevent the haemorrhage or cerebro vascular accident (CVA). According to Dr S the referral should have been done much earlier than 11 July. Based on all these findings Dr S was of the opinion that Mr D did not receive appropriate medical care. Dr S did address his mind to the question of consuming alcoholic drink on 10 July and said that, by consuming alcoholic drink it would in fact have aggravated Mr D's then prevailing condition and under such circumstances he should have been advised not to drink at all and such advice should have been recorded. He did testify earlier that if he drank moderately it would have been harmless to him. As to the question of the granting of medical leave of five days it meant nothing, so he testified.

Dr R testified that the blood pressure reading of 180/120 on 18 April for a man of 55 years of age was excessive, as the recommended reading was 160/90 and that under such circumstances he would have taken a detailed history of the patient followed by a physical examination including blood pressure reading and an ECG. Further, he would have given a provisional diagnosis of his medical condition, prescribed appropriate medication and given advice to the patient. He further testified that he would have ordered further investigation as may have been necessary, and that he would have referred him to a specialist. In reference to the notes of 3 July, Dr R testified that the doctor attending to Mr D on that date had diagnosed him as having CVI and had prescribed treatment for his condition, which was inadequate, in that there was no record of a blood pressure reading on this particular visit, that there was no record of any medical leave which should have been given in order for the patient to rest, that no advice on avoiding smoking, consuming alcohol and proper eating habits was given and that tests could have been done at that stage for risk factors associated with CVI which should have been done by the attending doctor without further referral to a hospital, and if for some reason or other he could not do the tests it was necessary for the doctor to refer the patient to a hospital. He testified that CVI is an indication of impending stroke. Dr R went on to testify that relying on the complaint of numbness of the right fingers, pain on the left eye on 6 and 10 July, being a few days after Mr D was diagnosed as having CVI, that further reinforced the previous diagnosis

of CVI as correct and that the ailment had progressed further and therefore it was imperative for the attending doctor, who should have been alert to the situation, to refer the patient to a specialist or a nearby hospital. Dr R was of the opinion that if all these had been adhered to it was apparent that there was a better chance of Mr D surviving. He added that parasthesia, which means numbness, is one of the warning signs of a stroke and this was evident as early as 6 July. This witness testified that granted the cause of death was haemorrhagic stroke, certain measures could have been taken by the doctor at the clinic which, if taken, may have had the effect of prolonging his life, one of the measures being documentation and control of his blood pressure. He added that the medication to reduce the blood pressure would have consisted of one of more than a hundred or more types and that on the analogy of plumbing and pipes, the higher the pressure, the higher the risk of bursting and haemorrhagic stroke. He testified that the said medication could take effect within three or four hours. Dr R went on to say in evidence that between 3 July and his demise it was important to admit Mr D to hospital so that his blood pressure could be brought down to a normal level and that by confining him to a closed environment of a hospital it would have been easier to manage his blood pressure. The matter was reduced to one issue and that was steps to reduce his blood pressure which steps should have been taken between 3 July and 10 July. Dr R testified to his belief that the straw that broke the camel's back was a rise in the blood pressure and as to Mr D's blood pressure on 10 July being normal, he said that blood pressure can change within hours.

On behalf of the second defendant, Dato' Dr Joseph Eravelly, a consultant cardiologist ('Dr E') testified that he concurred with the conclusion as to the cause of death being cerebral haemorrhage, also known as haemorrhagic stroke and also concurred with the findings of Dr S that the cause of death was cerebro vascular accident (CVA). Dr E explained that there are two types of stroke that an individual could suffer from, namely, ischaemic stroke and haemorrhagic stroke, that in the first type the blood vessels are blocked by a special kind of clot called a thrombus while in the second type a small blood vessel bursts causing bleeding. Dr E testified that there are no warning signs of the second type of stroke. It occurs suddenly. Dr E further testified that hypertension was a cause of haemorrhagic stroke but the cause had to be understood in the context of causing an increased risk, that the blood vessels in the brain and elsewhere had undergone decay and degeneration as part of the ageing process and hypertension enhances this degeneration. As to the first type Dr E said that in a small number of patients, ischaemic stroke is preceded by some warning symptoms and signs comprising weakness of the upper and lower limbs on one side, speech disturbances, visual defects and sensory disturbances, like numbness. He emphasized that the muscle weakness and visual disturbances were very important in this diagnosis and that numbness alone was an unreliable symptom. Based on the notes the deceased did not have any symptoms of transient ischeamic attack (TIA) because he complained of numbness only to Dr Y and that was a non-specific complaint; since he died of haemorrhagic stroke it was even more unlikely that those symptoms were due to TIA. He testified that Mr D's symptoms, including pain in the eye,

which is also sensation, were alone non-specific and non-indicative of a pending stroke.

On a question as to prescribing anticoagulants as a preventive measure in the treatment of stroke, Dr E said that there are two categories of drugs, one being antiplatelet drugs such as aspirin and persantin which in effect makes the blood thinner, and the other being anticoagulant drugs which interfere with the coagulation or clotting process, and that since it has been established that it was difficult to predict when a haemorrhagic stroke may occur, aspirin or persantin would not be used in the prevention of a haemorrhagic stroke. The aforesaid drugs would be prescribed against ischeamic stroke where there were clear signs and symptoms of TIA, and there was no reason for prescribing anticoagulants when it was apparent that it was a case of haemorrhagic stroke. As to whether the treatment prescribed by the doctors in the clinic, with particular reference to the selection of medication and the desired result, was good advice, Dr E said that relying on the blood pressure reading of 140/90 which was normal and under such circumstances, there was no need for any further treatment other than to treat the patient for hypertension, which in fact had been done. In the prevailing circumstances he would have recommended neither a CT scan nor a cerebral angiogram to the patient because one cannot predict the blood vessel that was going to bleed and the other reason being that there were no means of treating the condition, that knowing the condition of Mr D he would not have admitted him to hospital, and that anxiety and worry connected to Mr D's employment could have aggravated his condition leading to a stroke.

As to the need for keeping records of the case by Dr Y, Dr E said that it was important to understand what a general practitioner's practice was all about; it was a problem-solving quick fix facility where many patients are seen rapidly for relatively minor problems and at low cost. He said that in this case Dr Y apparently had seen Mr D, examined him and identified the problem as one of hypertension, then he fixed it by prescribing medication to reduce his blood pressure to normal levels, and therefore Dr Y had done what he ought to have done in the circumstances as a general practitioner like those working in the government service would do. Dr Y also had written brief notes of his findings for his own guidance and for follow-up action, and the medical profession does not expect him to behave like a specialist and write copious records.

The second defendant (Dr Y) testified saying that he was the owner and senior partner of the clinic. He further testified that on 6 July, Mr D was ambulant, coherent and had presented his symptoms to him. He had examined Mr D to find him very tense and worried with raised blood pressure, and he had started treatment on Mr D with Librium to relieve his tension and stress, Brufen to relieve the pain in the left eye and Brenerdine to control his blood pressure. He testified that on 6 July he saw no need for medical leave and Mr D's symptoms being non-specific and he appearing quite well, he saw no need to admit Mr D to a hospital or refer him to a specialist. On 6 July, when he saw Mr D, he was of the opinion that Mr D did not suffer from CVI notwithstanding the fact that he had read the recording of Dr W made on 3 July, so he testified, adding that if it was CVI

there must be definite signs of weakness on one limb or another, loss of speech, perhaps focal, disturbances of reflexes and a host of other neurological signs. In this case, Mr D only had numbness of the fingers and numbness of the fingers and a tingling sensation are very common symptoms presented by patients in general practice and he attributed the numbness to stress. Mr D was asked to come back for a review in a week's time. On 10 July Dr Y reviewed Mr D and said that Mr D appeared very well in the clinic though he had complained of greater stress; in view of the complaint, stronger tranquilisers, namely, Valium and Ponstan were prescribed. Medical leave of five days was given for Mr D to rest at home and it was for these reasons and that his blood pressure was under control that he did not consider Mr D needed urgent hospitalization or was there the need to refer Mr D to a specialist. Dr Y further testified that CAT scan, MRI scan and cerebral angiogram facilities were not available anywhere in the state of Johor, that even if such facilities were available, based on the non-specific symptoms and Mr D's reduced blood pressure which he attributed to stress, he would not have referred Mr D for the abovestated tests, and that even if he had admitted Mr D to the hospital on 10 July the hospital would have continued to monitor Mr D's blood pressure, prescribed some medication and probably ordered some tests to be done, namely, chest X-ray, blood and urine test. Dr Y also testified that on 10 July he was not aware of whether he was informed of Mr D's fits, slurring of speech, twitching of the arms, and eyes and had it been told to him, he would have definitely recorded it. He said that he did not receive a referral letter from the HA, and that he had not treated patients for the purpose of saving money for the estate.

Dr Y also testified that a general practice was similar to an outpatient department in a government hospital where they try to deal with minor ailments, follow up on long term sickness like diabetes, high blood pressure and asthma. He said that all these are done at minimal cost and that whenever there are cases which they cannot handle or in any emergency beyond their ability to manage, they would refer them to a hospital or to a specialist.

Dr W gave evidence saying that he was a junior partner at the clinic when he treated Mr D. Referring to his case notes, he remembered seeing Mr D on 18 April when he examined him and took note of his chest discomfort and pain in the epigastrium. He remembered that he had taken Mr D's pulse rate and blood pressure and that Mr D had told him that he was aware of his high blood pressure as he was receiving treatment from the doctor in the hospital. He had advised Mr D to avoid smoking and drinking alcohol, to avoid eating salty food and to take his medication regularly. He did not do an ECG on Mr D because he felt the symptoms were not of cardiovascular origin. He testified that he had physically examined Mr D and found his throat, pulse rate and temperature to be normal, that he had checked his blood pressure and found it to be high and had recorded it, and that he was not in the habit of recording normal findings in his notes.

Dr W, again relying on his case notes, recalled seeing Mr D on the night of 3 July when Mr D, complained of a tingling sensation in his right arm. The HA was there and had told him of Mr D's giddiness but Mr D

had appeared to be normal, coherent and could converse. He had physically examined Mr D and had not found any of the symptoms. On further examination he found that there was no sign of weakness in Mr D's right arm, that the CVI recorded was only a provisional diagnosis as there was inadequate blood supply to the brain which might have caused the tingling sensation in his right arm, and that such condition could have affected the small blood vessels in the brain. He prescribed Trental as medication that would help open up the small blood vessels and thus improve the blood circulation in the brain. He testified that under these circumstances he felt that there was no need for any further investigation or referral to a specialist and therefore further investigation was not carried out in view of the fact that Mr D was in good physical condition. Dr W further testified that there was no evidence of muscular weakness, slurring of speech or fainting. He admitted that he did not record the complaint of tingling sensation, his reason being that this symptom was a vague and non-specific complaint. The cases for the Estate and Dr Y were then closed.

The law applicable in this case and which binds me is to be found in the majority decision of Barakbah LP in the Federal Court case of *Swamy v Matthews & Anor* [1968] 1 MLJ 138 at pp 139 and 140 where it was stated:

> A man or a woman who practises a profession is bound to exercise the care and skill of an ordinary competent practitioner in that profession—be it the profession of an accountant, a banker, a doctor, a solicitor or otherwise. In the case of *Lanphier v Phipos* (1883) 8 Car & P 475 Tindal CJ laid down this principle:
>
> > 'Every person who enters into a learned profession undertakes to bring to the exercise of it a reasonable degree of care and skill. He does not undertake, if he is an attorney, that at all events you shall gain your case, nor does a surgeon undertake that he will perform a cure; nor does he undertake to use the highest degree of skill. There may be persons who have higher education and greater advantages than he has; but he undertakes to bring a fair, reasonable and competent degree of skill.'
>
> Again in the case of *Hatcher v Black & Ors* [1964] CLY 2289 Denning LJ (as he then was) said that, in a hospital when a person was ill and came in for treatment, no matter what care was used there was always a risk; and it would be wrong and bad law to say that simply because a mishap occurred the hospital and doctors were liable. Indeed, it would be disastrous to the community. It would mean that a doctor examining a patient or a surgeon operating at the table, instead of getting on with his work, would be for ever looking over his shoulders to see if someone was coming up with a dagger; for an action for negligence against a doctor was like unto a dagger; his professional reputation was as dear to him as his body—perhaps more so. And an action for negligence could wound his reputation as severely as a dagger could his body. The jury must therefore not find him negligent simply because one of the risks inherent in an operation actually took place, or because in a matter of opinion he made an error of judgment. They should find him guilty when he had fallen short of the standard of reasonable medical care, when he was deserving of censure.

Swamy's case was decided in 1967 and the comment of what would be disastrous to the community was made then. At this point, some 30 years

down the track of time, that disaster has come to bear on the communities of certain so-called developed countries, where instead of doctors practising medicine confidently and comfortably as they were wont to do in yesteryear, they in those communities do indeed cower in anticipation of being stabbed, melodramatic as the metaphor may have been in 1967 but less so now in the light of the current situation when doctors are preoccupied with safeguarding themselves against potential claims for negligence. Gone are the days of giving gratuitous advice and rendering assistance, for example in a road accident or like emergency, without thought of ill consequences of the advice or assistance. At great expense to the community, these doctors carry out an interminable series of tests, most or a number of which are unnecessary, with the sole object of not being, at some later stage, forensically accused of not having carried out those tests. It is sheer madness to practise medicine without a large insurance policy against malpractice across the spectrum. The financial burden is passed on to the patient who in turn has perforce to be insured against the doctor's fees and outgoings which the patient can, if the pun may be excused, ill-afford to pay. In certain of these communities that are socialist, the community passes its financial burden on to the government which then imposes a tax on the income of the doctor and the latter increases his fees to absorb the tax that has to be paid to the government and the circus goes on ad infinitum. Mercifully that scourge has not as yet descended upon our community. I consider it as being the duty of the court to protect our society in the application of the law and not to open the floodgates to litigation against doctors founded on negligence. The forensic dagger is to be wrested from the grip of the legal practitioner, the scalpel vested in the confident hands of the surgeon as the stethoscope is in that of the medical practitioner. That to my mind should be the position by and large. It does not mean however that doctors are at liberty to practise their profession as they think fit, hurriedly or as a 'problem-solving quick fix facility where many patients are seen rapidly for relatively minor problems and at low cost', yet no doubt in some cases with the till constantly ringing in the profit. Such an approach strikes me as being casual and off-hand and in discord with the proper practice of medicine. As stated in *Swamy*'s case, and it bears repeating, a medical practitioner is bound to exercise the care and skill of an ordinary, competent practitioner in that profession.

Without in any way detracting from that proposition I should say that the current state of the law, by way of elaboration, may be found in the decision of the High Court of Australia given in *Rogers v Whitaker* (1992) 175 CLR 479. In that case the appellant, an eye surgeon, performed surgery on the respondent's eye resulting in blindness in both her eyes, the risk of which was very slight. The appellant had not warned the respondent beforehand of that risk, which the High Court found was a material risk which entailed a duty to warn and accordingly dismissed the appeal. The case is important not for its facts but the principle enunciated by the judges of that court. At p 483, in deciding on the issue of whether there was a breach of duty on the part of the appellant, the court held thus:

> The law imposes on a medical practitioner a duty to exercise reasonable care and skill in the provision of professional advice and treatment. That duty is a 'single comprehensive duty covering all the ways in which a doctor is called upon to exercise his skill and judgment' (*Sidaway v Governors of Bethlem*

Royal Hospital [1985] AC 871, per Lord Diplock at p 893); it extends to the examination, diagnosis and treatment of the patient and the provision of information in an appropriate case (*Gover v South Australia* (1985) 39 SASR 543 at p 551). It is of course necessary to give content to the duty in the given case.

The standard of reasonable care and skill required is that of the ordinary skilled person exercising and professing to have that special skill (*Bolam v Friern Hospital Management Committee* [1957] 2 All ER 118 at p 121; see also *Whitehouse v Jordan* [1981] 1 All ER 267, per Lord Edmund-Davies at p 277 and *Maynard v West Midlands AHA* [1985] 1 All ER 635, per Lord Scarman at p 648) ...

Further at p 483, the court held thus:

The principal issue in this case relates to the scope and content of the appellant's duty of care: did the appellant's failure to advise and warn the respondent of the risks inherent in the operation constitute a breach of this duty? The appellant argues that this issue should be resolved by application of the so-called *Bolam* principle, derived from the direction given by McNair J to the jury in the case of *Bolam v Friern Hospital Management Committee* [1957] 2 All ER 118. In *Sidaway v Governors of Bethlem Royal Hospital* [1985] AC 871 at p 881, Lord Scarman stated the *Bolam* principle in these terms:

> 'The *Bolam* principle may be formulated as a rule that a doctor is not negligent if he acts in accordance with a practice accepted at the time as proper by a responsible body of medical opinion even though other doctors adopt a different practice. In short, the law imposes the duty of care: but the standard of care is a matter of medical judgment.'

The court, at p 487, went on to hold as follows:

In Australia, it has been accepted that the standard of care to be observed by a person with some special skill or competence is that of the ordinary skilled person exercising and professing to have that special skill (*Cook v Cook* (1986) 162 CLR 376 at pp 383–384; *Papantonakis v Australian Telecommunications Commission* (1985) 156 CLR 7 at p 36; *Weber v Land and Business Agents Board* (1986) 40 SASR 312 at p 316; *Lewis v Tressider Andrews Associates Pty Ltd* [1987] 2 Qd R 533 at p 542). But, that standard is not determined solely or even primarily by reference to the practice followed or supported by a responsible body of opinion in the relevant profession or trade (see, for example, *Florida Hotels Pty Ltd v Mayo* (1965) 113 CLR 588 at pp 593, 601). Even in the sphere of diagnosis and treatment, the heartland of the skilled medical practitioner, the *Bolam* principle has not always been applied (see *Albrighton v Royal Prince Alfred Hospital* [1980] 2 NSWLR 542 at pp 562–563 (case of medical treatment). See also *E v Australian Red Cross Society* (1991) 99 ALR 601 at p 650) ...

In *F v R* (1983) 33 SASR 189, which was decided by the full court of the Supreme Court of South Australia two years before *Sidaway* in the House of Lords, a woman who had become pregnant after an unsuccessful tubal ligation brought an action in negligence alleging failure by the medical practitioner to warn her of the failure rate of the procedure. The failure rate was assessed at less than 1% for that particular form of sterilization. The court refused to apply the *Bolam* principle. King CJ said (ibid, at p 194):

> 'The ultimate question, however, is not whether the defendant's conduct accords with the practices of his profession or some part of it, but

A whether it conforms to the standard of reasonable care demanded by the law. That is a question for the court and the duty of deciding it cannot be delegated to any profession or group in the community.'

King CJ considered (ibid, at pp 192–193) that the amount of information or advice which a careful and responsible doctor would disclose depended upon a complex of factors: the nature of the matter to be disclosed; the nature of B the treatment; the desire of the patient for information; the temperament and health of the patient; and the general surrounding circumstances. His Honour agreed with (ibid, at pp 193–194) the following passage from the judgment of the Supreme Court of Canada in *Reibl v Hughes* (1980) 114 DLR (3d) at p 13:

C 'To allow expert medical evidence to determine what risks are material, and, hence, should be disclosed and, correlatively, what risks are not material, is to hand over to the medical profession the entire question of the scope of the duty of disclosure, including the question whether there has been a breach of that duty. Expert medical evidence is, of course, relevant to findings as to the risks that reside in or are a result of recommended surgery or other treatment. It will also have a bearing on D their materiality but this is not a question that is to be concluded on the basis of the expert medical evidence alone. The issue under consideration is a different issue from that involved where the question is whether the doctor carried out his professional activities by applicable professional standards. What is under consideration here is the patient's right to know what risks are involved in undergoing or foregoing certain surgery E or other treatment.'

The approach adopted by King CJ is similar to that subsequently taken by Lord Scarman in *Sidaway* and has been followed in subsequent cases (*Battersby v Tottman* (1985) 37 SASR 524; *Gover v South Australia* (1985) 39 SASR 543 at pp 551–552; *Ellis v Wallsend District Hospital* (unreported) Supreme Court of New South Wales, 16 September 1988; *E v Australian Red Cross Society* F (1991) 99 ALR, at pp 649–650). In our view, it is correct.

Acceptance of this approach does not entail an artificial division or itemization of specific, individual duties, carved out of the overall duty of care. The duty of a medical practitioner to exercise reasonable care and skill in the provision of professional advice and treatment is a single comprehensive G duty. However, the factors according to which a court determines whether a medical practitioner is in breach of the requisite standard of care will vary according to whether it is a case involving diagnosis, treatment or the provision of information or advice; the different cases raise varying difficulties which require consideration of different factors (*F v R* (1983) 33 SASR 189 at p 191). Examination of the nature of a doctor-patient relationship compels this conclusion. There is a fundamental difference between, on the one hand, H diagnosis and treatment and, on the other hand, the provision of advice or information to a patient. In diagnosis and treatment, the patient's contribution is limited to the narration of symptoms and relevant history; the medical practitioner provides diagnosis and treatment according to his or her level of skill.

I Senior counsel for the second defendant cited *Bolam v Friern Hospital Management Committee* [1957] 2 All ER 118 and the principle ('the *Bolam* principle') enunciated by McNair J at p 122 as follows:

> A doctor is not guilty of negligence if he has acted in accordance with a practice accepted as proper by a responsible body of medical men skilled in that particular art. I do not think there is much difference in sense. It is just a different way of expressing the same thought. Putting it the other way round, a doctor is not negligent, if he is acting in accordance with such a practice, merely because there is a body of opinion that takes a contrary view.

Counsel also cited the case of *Elizabeth Choo v Government of Malaysia & Anor* [1970] 2 MLJ 171 where at p 172 Raja Azlan Shah J (as he then was) stated (quoting Lord Clyde in *Hunter v Hanley* (1955) SLT 213 at p 217):

> In the realm of diagnosis and treatment there is ample scope for genuine difference of opinion, and one man clearly is not negligent merely because his conclusion differs from that of other professional men. ... The true test for establishing negligence in diagnosis or treatment on the part of a doctor is whether he has been proved to be guilty of such failure as no doctor of ordinary skill would be guilty of it acting with ordinary care.

Counsel then submitted that the judgment in *Elizabeth Choo*'s case had been expressly adopted by the Federal Court in *Kow Nan Seng v Nagamah & Ors* [1982] 1 MLJ 128, the implication being that I am bound by the latter case and consequently I am to apply the *Bolam* principle to the instant case.

In *Kow*'s case the respondent had suffered a fractured leg. A doctor applied a complete plaster cast, known as the POP long boot to the leg in such a manner as to cause inadequate blood circulation resulting in gangrene setting in and eventually amputation of the leg. The question before the court was whether the doctor and the hospital that employed her were guilty of negligence in applying the POP long boot to the respondent's leg. As to the law on medical negligence, Salleh Abas FJ, in delivering the unanimous judgment of the court at p 129 ruled thus:

> A doctor's duty towards this patient is that he has to exercise a fair and reasonable standard of care and skill, ie the skill of an ordinarily competent medical practitioner (*R v Bateman* [1925] All ER 45).

The unchallenged evidence in that case showed that the treatment could be either a complete cast or a plaster slab and that the practice in Malaysia is to apply a complete cast. The medical expert who was consulted by the respondent's counsel disputed this current Malaysian practice to be a correct one and, maintained that a plaster slab should be used and that this method is within the knowledge of an ordinary doctor, presumably like the doctor who attended to the respondent. The learned judge went on at p 130 to state:

> There may be differences of opinion as to the types of plaster casts to be applied in the treatment of the type of injuries sustained by the respondent, but the choice of a treatment which is the standard medical practice is not by itself a negligence (*Bolam v Friern Hospital Management Committee* [1957] 2 All ER 118 and *Elizabeth Choo v Government of Malaysia & Anor* [1970] 2 MLJ 171). Thus the application of POP long boot to the respondent's left leg is not in itself a negligent act. However, since the application of POP carries with it an inherent danger to blood circulation, the question is whether there was fair and reasonable standard of care taken after POP was applied to see that there would be no problem of poor blood circulation. If there was such

A standard of care [the doctor who attended to the respondent] would not be liable, but if there was not, [the doctor] would be liable ...

For my part I see *Bolam*'s case and that of *Elizabeth Choo* being referred to by the learned judge not for a proposition that there being differences of opinion as to treatment, choice of a treatment which is the standard B medical practice is not by itself negligence. I do not see the learned judge as having addressed himself to the *Bolam* principle and upon doing so applying it. Accordingly I do not find myself by reference to *Kow*'s case being fettered by the *Bolam* principle but on the contrary bound by the ruling of Salleh Abas FJ, set out above which ruling corresponds with the ruling by the then Lord President in *Swamy*'s case and I propose to adopt C by way of elaboration of those rulings the abovementioned dicta extracted from the decision in the *Rogers*' case. I should emphasize that while due regard will be had to the evidence of medical experts, I do not accept myself as being restricted by the establishment in evidence of a practice accepted as proper by a responsible body of medical men skilled in that particular art D to finding a doctor is not guilty of negligence if he has acted in accordance with that practice. In short I am not bound by the *Bolam* principle. Rather do I see the judicial function in this case as one to be exercised as in any other case of negligence, unshackled, on the ordinary principles of the law of negligence and the overall evidence.

E As I see it, by reference to the pleadings and the evidence, the complaint of the plaintiffs was in regard to the alleged breach of duty to take care on the part of Dr Y and Dr W in respect of the attendances of Mr D at the clinic on the three occasions in July and not the attendance in April. It would appear that it was only after analysis of the respective expert opinions, when it became clear that the main thrust of the argument F of the defence was whatever Dr Y and Dr W did or omitted to do had no bearing on the death of Mr D, that attention was directed to Mr D's April attendance before Dr W and a claim in negligence sought to be established on the basis of what Dr W omitted to do on that occasion. Senior counsel for Dr Y submitted that such a claim was not envisaged in the statement of claim and especially the particulars of negligence pleaded therein. G Scrutiny of the plaintiffs' pleadings, to my mind, did not disclose the claim as embracing such an act or omission by Dr Y or his servants or agents on 18 April. However, bearing in mind that pleadings exist mainly to provide against an opposing party being taken by surprise, that there was no such surprise, that witnesses testified without objection to the episode on 18 H April and, indeed, that the said episode was referred to in Dr Y's counsel's written outline of submission prepared before any submission by plaintiffs' counsel of Dr W's said omission as a ground of negligence, I treated the said episode as being legitimately in issue. To have excluded the episode from judicial consideration would have been to afford to the defendants perpetration of the very same mischief they themselves were complaining I of, to wit surprise, inasmuch as they were taking the point in their final submission, well after the evidence was closed.

However, I do not see any breach of duty on the part of Dr W in failing to treat the deceased for hypertension in April. I accept Dr W's testimony in this regard. He was cross-examined unsparingly but came

through unshaken. There was no evidence of the deceased being of abnormally low intellect. Accordingly I accepted him as having been an adult of normal intellect. He told Dr W at the April attendance that the Kluang Hospital was then treating him for hypertension. That being the case it seemed to me reasonable for Dr W not to treat him for hypertension but to leave the Kluang Hospital to do so. To have done so would in fact in the circumstances have been dangerous. For Dr W to have inquired further as to what the hospital treatment was, was to my mind to demand of Dr W something beyond what was reasonably required of him and indeed professionally improper to do. I consider it was reasonable for Dr W, once he was informed by this normal, adult person that he was being treated for hypertension by the Kluang Hospital to assume that treatment to be a fact and adequate.

I find that Dr W correctly diagnosed Mr D's complaint on this occasion, which was chest discomfort, as gastritis (incidentally the HA's records show he had had an attack of gastritis on 13 March) and correctly also prescribed the treatment. I find the visit was because of this complaint only and had nothing to do with his hypertension in respect of which he was being treated at the point of time by the Kluang Hospital. I also find that Dr W took his blood pressure reading as a matter of routine having observed there was chest discomfort, as any prudent general medical practitioner would and finding it to be high was concerned for its treatment, as would reasonably have been expected, but declined to treat him for it for the reasons abovestated, the underlying facts perforce having to be true for otherwise there would have been no reason for Dr W not to have treated Mr D then for his high blood pressure. He having indisputably taken the reading and recorded it as high, the natural consequence would have been to treat it unless there was good reason to the contrary. In any event, even if it can be said that there was a duty on the part of Dr W so to inquire, the fact remains that there was sufficient evidence to establish conclusively that Mr D was then being so treated, (see the HA's evidence and records abovestated) and that treatment was adequate as vouched for by Dr E and whose testimony in this regard was not challenged by either Dr S or Dr R. Mr D having himself told Dr W that he was then being treated at the hospital for hypertension, it would have been futile for Dr W to have referred him to the hospital. The HA's records, produced and marked as an exhibit, disclosed that in the intervening period between Mr D's first and second visits to the clinic, more particularly on 12 May, 19 May and 13 June his blood pressure was taken and found to be normal. The readings were 110/70, 120/80 and 120/80 respectively. The exhibit also disclosed that in that intervening period he was being treated for high blood pressure, and I specifically asked Dr E with reference to that exhibit whether Mr D appeared to have been treated adequately in the intervening period and he testified in the affirmative.

Every case has to be decided on its own facts and circumstances. Accordingly I was obliged to apply my mind to the situation facing the general medical practitioner attending to a patient in a clinic in Kluang in the year 1984. Mr D lived, as we all do, in a free society which includes such medical facilities as are available at the place we reside at a particular

point of time. His treatment for hypertension was by and large in his own hands. He was free to seek treatment or not to do so. The only reservation was that if he sought such treatment at the expense of his employer, the first defendant, he had to abide by the terms of his contract of service. Mr D, like every other free adult person was entitled to choose the quality of his life. He was a smoker from the time of his marriage 26 years before his death. According to his wife he drank moderately. He was free to do those things despite the prognosis of a shortened expectation of life. It is common knowledge that smoking and drinking excessively is bad for hypertension. Mr D, being a person mature in years and suffering for a long time from hypertension for which he has been medically treated hardly needed a doctor to tell him at a late stage to abstain from tobacco and liquor, especially when his wife had probably been telling him so for years before he saw the particular doctors concerned.

I believe both doctors, like Mrs D, advised him against drinking and smoking and worrying. It would have come as second nature to the doctors so to advise given the circumstances. I believe that if the doctors did not advise so, it was because of the futility of doing so as Mr D must well have known that he must not do these things. It would seem on the evidence that the deceased did not or was not able to put into effect that advice.

As to the visit on 3 July, according to the pleadings, on that day at about 4.30pm Mr D while working complained of giddiness at the Estate office. There is no mention in the pleadings of fainting, slurring, twitching of the right arm and numbness of the right hand lasting for about five minutes as testified by the HA. His record in fact shows an entry on 2 July to the effect that Mr D complained of vertigo, which is synonymous with giddiness. I do accept however that he had fainted at work that day because Mrs D corroborated the HA's testimony in that regard and I accept Mrs D as a truthful witness in all she testified to. Also his condition that day must have been serious for him to have been brought to the clinic accompanied not only by Mrs D but also the HA. I think this fainting episode was the first visual indication that there was something seriously amiss with Mr D for Mrs D testified that before he went to work that day he did not complain about anything, and it has to be recalled that that morning, as testified by the HA, he had been riding his motorcycle. Mrs D herself testified that Mr D only complained to Dr W of numbness in the right arm and pain on the left eyebrow and this is corroborated to some extent by Dr W in that he examined the right arm but found no weakness in it. Dr W testified that he had not been told of the slurring or fainting. I accepted his testimony in regard to the former but not the latter because it was the fainting which brought the entourage to the clinic and in the circumstances it would have been strange that he was not told of this salient episode. At any rate Dr W had to have known his condition to be serious, for on examination of Mr D, his diagnosis was that he was suffering from CVI. Dr W prescribed treatment on this occasion but in view of the finding of CVI, he should, as stated by Dr R in evidence and in his report and corroborated by the testimony of Dr S, have recognised

the CVI as a warning sign of an impending stroke and immediately admitted him to hospital. A

As to the visit to the clinic on 6 July, Mr D, who as stated above was attended to by Dr Y, had a blood pressure of 190/110 which was high, and he complained of parasthesia or numbness of the right fingers and left eye pain and Dr Y found him to be very tense and worried. The HA's record for 7 July, which both parties agreed should have read 6 July, indicated a complaint of vertigo only. Mrs D said of this visit that Mr D complained of pulling about the lips when he tried to talk; the lips were going to one side. I find that Dr Y should not, as a general practitioner, have undertaken the management of Mr D in the circumstances himself but that he should have either referred him to a cardiologist or neurologist if readily available, or otherwise had him admitted to hospital and again I base my finding on the evidence and opinions of Dr R and Dr S. I also find that he failed in his duty as a doctor to his patient in deciding not to admit him so and in deciding that medical leave was not necessary and therefore declining to give it. It goes to the credit of the HA that he took it upon himself to prescribe two days leave of absence on 6 July. B C D

In the textbook *Medical Negligence* by Michael Powers and Nigel Harris at p 425 paras 20.28, 20.29 and 20.30, it is pertinently stated as follows:

> 20.28 In the cases on which I have been asked to give an opinion regarding the possibility of negligence in general practice there have always been one or two critical points in the flow of events when the question had to be asked 'Would the average general practitioner have been expected to have taken this or that particular course of action?' For example: E
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> — Did the general practitioner examine or take an adequate history and was it *recorded*? F
>
> — Was it reasonable to prescribe a course of antibiotics at this point?
>
> — Should the general practitioner have visited the patient at home?
>
> — Should the patient have been referred to a specialist? G
>
> 20.29 General practitioners will not get into trouble if they use their common sense and follow the rules:
>
> — listen attentively
>
> — examine H
>
> — treat and explain carefully and courteously
>
> — record
>
> — visit at home or refer to a specialist when necessary
>
> — keep up to date I
>
> — have the patient's welfare in mind all the time
>
> — if in doubt, record this doubt and do any necessary tests.

> 20.30 A good doctor/patient relationship in general practice may avoid the patient resorting to legal action partly in order to obtain a full explanation of what really happened—something which patients need in order to resolve the events in their own minds. Dr Garth Hill, writing in the Winter 1988 edition of the Journal of the Medical Defence Union has reiterated the MDU's view that 'the patient is entitled to a prompt, sympathetic and above all truthful account of what has occurred'.

Regretfully I have to say that both Dr W and Dr Y failed the above tests rather badly. Here was a man of 55 years with a long history of hypertension, a heavy smoker, worried and tense about him approaching probably (and as it turned out) the final cross road in his life, namely, his retirement from employment by the Estate, being brought 25 miles on 3 July to the clinic, being ill enough to be accompanied not only by his wife but also the HA. Dr W correctly diagnosing him as having CVI but then instead of immediately having him admitted to hospital for rest and proper management including tests and appropriate medication, he sends him home without even giving him leave. To say that the patient did not want leave was a poor excuse. Dr W should have advised him and indeed Mrs D of the seriousness of the situation and ordered immediate and effective rest besides admitting him to hospital.

If Dr W's conduct towards his patient was wanting, as I consider it was, Dr Y's approach on 6 and 10 July was worse. This is what Mrs D said in evidence:

> My husband wanted to be admitted to the hospital. He asked Dr Y to admit him to the hospital because he feared [if] anything happens to him [it would be] very difficult for him to go to hospital because of the road conditions and the distance from Estate when we were driving to Kluang Hospital. Dr Y replied that it was not necessary. My husband even asked for medical leave. Dr Y did not give the leave. My husband told him he was working in the field and was scared if anything happened—anything can happen to him. Then Dr Y gave two days off. He then asked us to go home. He did not say anything else.

I think Mrs D was mistaken above the leave. It was not Dr Y who gave the leave. It was the HA who did so. Mrs D's testimony as to what transpired on 10 July with Dr Y is as follows:

> The next morning 10 July 1984, I and my husband went to clinic by estate ambulance with the HA's recommendation letter. At the clinic my husband gave the letter to Dr Y and told him about the conditions. He was having the same symptoms and also the pulling of the right arm and he insisted that he wanted to be admitted to the hospital but Dr Y said it was not necessary. Then he changed [the] medication and gave five days off and asked us to go back home.

Here then was the real complaint of the plaintiffs and one which was pursued from the beginning and throughout these proceedings. It was against Dr W at the attendance on 3 July but more so against Dr Y at the attendances on 6 and 10 July for he did not heed the request of the deceased to refer him for admission to the Kluang Hospital or the JB Hospital.

I feel it was a lame excuse for Dr Y to say as he did in evidence that as many as 5% to 10% of the population suffers from high blood pressure and if every such patient, especially those with a long history of it and who had been treated, were referred or admitted to hospital, the total number of hospital beds in our country would not be able to take them. That was not the criterion. Dr Y's duty was to apply his mind and his professional skill to his patient Mr D as required by the law abovestated.

In his evidence given in cross-examination, Dr Y appeared to be conceding his default. He testified that stress made Mr D a higher risk than one with high blood pressure without stress and that he had to be treated with great care. He testified that greater care would entail frequent monitoring of his high blood pressure level, taking the pulse rate, listening to his heart, examining the limbs because he had complained of numbness and also to examine the nervous system to see if the numbness was related. Dr Y testified that this was the physical examination he carried out on Mr D. That to my mind was inadequate. Quite simply the frequent monitoring of his blood pressure could only be done in a hospital with him admitted therein as a patient. Dr Y did not agree with Dr W's finding of CVI on 3 July as abovestated. That was a serious thing. Yet there is no evidence that he consulted Dr W to find out why Dr W diagnosed CVI. Instead he testified that he was unaware of Dr W saying that the small arteries were going into spasms and that that was why Mr D was feeling that kind of attack. Then came this exchange:

Senior counsel for plaintiffs:	I put it to you that the HA on 10 July 1984 has urged you by way of that letter and orally to urgently refer this patient to the hospital or to a specialist and you said there was no need.
Dr Y:	I am not even sure of the events. If a patient himself asked to be referred to a hospital I would not overrule him. In this particular situation the HA would be in a better position than the patient to know whether the patient should be referred to a hospital or not. I cannot recall having said that in answer to a request by the deceased to be referred to a hospital on 10 July 1984, that it was not necessary. Again I cannot recall whether by reason of the deceased so requesting I changed the medication and then gave him five days leave.

Initially I had considered it incongruous that the HA should write to Dr Y who was effectively his professional superior advising Dr Y to admit Mr D to hospital. I thought it audacious if not impertinent of him to do so. The record will show that I questioned him quite intensely and extensively on the point but he remained adamant. Now with Mrs D's testimony to corroborate his evidence, fortified by Dr Y's testimony to the effect that he was not sure of the events, I accept the HA's testimony in this regard as true and have to add that it was a courageous and humanitarian thing for him to do. Finally in cross-examination this witness said:

> On hindsight, with the knowledge of the partner as alleged in his own reasoning as on 3 July 1984 and the HA's notes and what the patient is

> alleged to have told me on 10 July 1984, assuming those facts, it would have been preferable to refer him for admission to hospital.

I find that there was a conflict of interest between the doctor and patient relationship vis-a-vis the doctors and Mr D and the financial relationship between the Estate and the doctors, and that as a result, the judgment of the doctors in treating Mr D was consciously or subconsciously clouded and slanted in favour of the Estate and against Mr D. I find that if the doctors were not dependent on the Estate for their employment as visiting medical officers and placed on the Estate's panel of doctors but placed by some independent body, or selected by the patient himself, Mr D would have received satisfactory treatment from the doctors. Dr Y had said in evidence that if he advised that a patient needed to be admitted to the hospital, the Estate would do so and in that event the hospital would charge the Estate for hospital services. Senior counsel for the plaintiffs then put it to him that that was precisely the reason why he did not refer him to the hospital to which Dr Y thought that was a very serious insinuation on counsel's part and answered so adding that it was not true. A fortiori should the doctor be appointed by an independent body or the patient. It would be fairer to the patient and save embarrassment to the doctor.

The plaintiffs pleaded that Dr Y was the doctor of the Estate at all material times and had his medical practice under the name and style of Yoong Clinic at No 35, Jalan Dato Captain Ahmad, Kluang and all this Dr Y admitted in his defence. The plaintiff went on to plead that on 3 July at the clinic he was attended to by Dr W. Dr Y in his defence denied that Mr D was seen by Dr Y's servant or agent on 3 July but by one Dr Wong. The plaintiffs went on to plead that the death of Mr D was caused by or was due to the negligence of the defendants and/or their servants or agents and this the defendants denied. During the trial there was mention in the evidence of Dr W being a partner of Dr Y but no issue was joined as to the legal capacity of Dr W in relation to Dr Y. Well after the respective cases were closed, in the final written submission of counsel for Dr Y there was stated the following:

> It is probably pertinent at this point to determine in what capacity Dr Wong has been involved in this proceedings. It is clear that he has not been named as a defendant although the treatment rendered by him to the deceased patient Dinason on 3 July has been specifically referred to at para 5 of the statement of claim.
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> It is possible that the plaintiffs are alleging that such treatment was also negligent and Dr Yoong (sic) is liable as a servant or agent of Dr Yoong since at para 12 of the statement of claim the particulars of negligence of the 'second defendant and/or their servants and/or agents' is referred to. However, it is clear that Dr Wong is not a servant or agent of Dr Yoong and is in fact a partner who practises at his clinic and this has been clearly set out in the defence of the second defendant at para 4(i) stating that the second defendant denies that the deceased was seen by the second defendant's servants or agents on 3 July 1984. This defence is dated 2 August 1986. The plaintiffs have all along been aware that on 3 July the patient was treated by Dr Wong and not Dr Yoong as stated by them in para 5 of the statement of claim.

In the premises Dr Yoong cannot be liable for any purported breach of care by Dr Wong although the treatment and findings or lack of findings of abnormalities may be pertinent in the treatment rendered by Dr Yoong subsequent to Dr Wong.

I do not accept the submission. The professional relationship between Dr Y and Dr W was exclusively within their knowledge. The plaintiffs knew nothing of that. By reference to the pleadings and the evidence, Dr Y admitted that the practice was his, so a presumption arose that Dr W was his servant or agent. By way of analogy as in the case of *Barnard v Sully* (1931) 47 TLR 557, where a plaintiff in an action for negligence proves that damage has been caused by the defendant's motorcar, the fact of ownership of the motorcar is prima facie evidence that the motor car, at the material time, was being driven by the owner, or by his servant or agent. Having admitted to the practice being his, the defence as to the position of Dr W was vague, calculated to take the plaintiffs by surprise and in breach of the requirements and spirit of O 18 r 8(1) of the Rules of the High Court 1980. Raising the issue at the eleventh hour is tantamount to trial by ambush and is not permissible (see *Asia Hotel Sdn Bhd v Malayan Insurance (M) Sdn Bhd* [1992] 2 MLJ 615). In any event, Dr Y is liable for any default of the partner and the pleadings are amendable, there being in my view nothing to show that Dr Y will be thereby prejudiced. Furthermore the defendants failed to establish the true legal position between Dr Y and Dr W. The onus could not be said to have been discharged simply by Dr Y saying Dr W was his partner or vice versa, the more so when he claimed the practice to be his. There was no evidence that Dr Y knew the legal implication of a partnership at law. The practice being his, it is as likely that Dr W was his paid employee on a profit sharing basis.

I do not consider it my function here to pronounce any ruling on the making, for medico-legal reasons, of case notes by general medical practitioners or the form, manner or extent thereof. I would however venture to observe from a common sense point of view that I prefer in this regard the evidence of Dr E to that of the plaintiffs' specialist, who, to my mind, were too idealistic and impractical in their respective opinions. I had the impression that they were considering the problem from the position of a specialist consulted by Mr D and having all the resources available to them as such in Johor Bahru and Kuala Lumpur respectively, notwithstanding that they claimed to testify from the point of view of a general practitioner. It would be a sorry day if general practitioners find themselves preoccupied with making copious notes for fear of being stabbed by the forensic dagger instead of getting on with the work they are skilled at doing in service to the community at large. The question that arises in that regard is whether the fact that Mr D was not hospitalized caused or contributed to the cause of his death. The answer in my view is in the affirmative.

I did not consider Mr D attending the Hari Raya party as operating against the plaintiffs' claim. It had to be borne in mind that Dr Y had sent him home on medical leave and not had him admitted into hospital. It has to be remembered that Mr D at that time was depressed. What was

imperative at the time was his admission into hospital so that his blood pressure could be monitored frequently and based on the consequent readings, appropriate treatment given. That being denied and he being sent home, there being no evidence of Mr D being medically ordered to be confined to his bed, I felt it was not unreasonable for him to attend the Hari Raya party at the manager's house which, after all, was only a five-minute walk from his home. On the contrary I considered such a step prudent if for nothing else then at least hopefully to divert his mind from his depression; in short to cheer him up.

I regard all references direct or oblique to Mr D drinking at the party as irrelevant and calculated to prejudice the mind of the judge. I find there is no evidence of strong drink being served at the party and certainly there was no evidence of Mr D partaking of liquor at the party.

I find Dr Y vicariously or as a partner liable for the acts of Dr W. I find on the law abovestated and on the overall evidence that Dr Y breached his duty of care to Mr D and to the plaintiffs in the failure of having Mr D admitted to hospital on the days in July when Mr D was attended to at the clinic or any of those days. I accepted the evidence of Dr R especially, and that of Dr S insofar as Dr S's testimony corroborates that of Dr R that had Mr D been admitted to hospital, his life would have been prolonged. As to how long Mr D's life could have been so prolonged, I prefer the evidence of Dr R to that of Dr S and find that it is quite impossible to assess for how much longer Mr D would have lived had he been properly and at the right time admitted to hospital by Dr W and/or Dr Y. Mr D, because of his chosen lifestyle and habits as related to his illness should himself be taken as having elected for a reduced expectation of life. Such being the case I am minded to award only nominal damages following Dr Y's breach of duty giving rise to damage.

Accordingly there will be judgment for the plaintiffs against the second defendant for damages in the sum of RM1,000 and funeral expenses of RM1,500. As to costs, I find that by reason of the complexity of the facts of this case, in particular the medical evidence and the conflicting evidence of the medical specialists and the law also being complex, this action was properly brought in this court. The plaintiffs are to have costs of the action to be taxed. I find that this is a proper case for more than one counsel to have appeared for the plaintiffs and accordingly pursuant to O 59 r 19(1) of the Rules of the High Court 1980 I do certify that fees for two counsel for the plaintiffs be allowed, such costs to be paid by the second defendant.

As to the claim against the Estate I find that the Estate was negligent in failing to provide an efficient ambulance service at the material time complete with ancillary service therein including oxygen. It was argued that the Estate was under no legal obligation to provide an ambulance service. My view is that the Estate having provided the service gratuitously, was thereafter under an obligation to ensure that it was a proper ambulance service even if there was no legal requirement. However, it is my view that the Estate was required by law so to do pursuant to the provisions of s 18

of the Workers' Minimum Standards of Housing and Amenities Act 1990 (Act 446). Section 18 reads as follows:

> (1) It shall be the duty of the employer and of the resident manager at their own expenses—
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> (a) to have every worker employed on the estate and any dependant of such worker who requires medical treatment to be transported safely without delay to and from the hospital provided for workers employed on the estate or, if there is no such hospital, to and from the nearest government hospital; and
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> (b) to make such arrangements and to provide such appliances for the safe transport of a sick worker or any sick dependant of a worker to and from hospital as the medical officer of health or any medical officer may, from time to time, require.

However, though the failure to do so constitutes an offence under Act 446, the evidence discloses no nexus between the Estate's default abovestated and the cause of Mr D's demise.

Be that as it may, I find that it was reasonable for the plaintiffs to have brought an action against the Estate by reason of the Estate's negligence as abovestated and the fact that it was not easily ascertainable whether or not there was a causal connection between the Estate's negligence and the demise of Mr D. Any ordinary person acting reasonably would have sued the Estate because of its shoddy and deplorable ambulance service with no oxygen. The requirements of the law are clear and need no further elaboration. The phrase 'to provide such appliances for the safe transport of a sick worker ... to and from hospital ...', given its ordinary meaning renders it obvious that the Estate was legally obliged to provide an ambulance service with instruments and apparatus including oxygen to ensure the safe transport of Mr D to the clinic. Accordingly as between the plaintiffs and the Estate I make no order as to the costs of the action.

Reported by Pearl Wee